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No. 96-316

IN THE

Supreme Court of the United States

OCTOBER TERM, 1995

STATE OF LOUISIANA, EX REL. RICHARD P. IEYOUB, Attorney General,

Petitioner,

v.

CIGNA HEALTHPLAN OF LOUISIANA, INC. and CONNECTICUT GENERAL LIFE INSURANCE COMPANY,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

RESPONSE TO PETITION FOR A WRIT OF CERTIORARI

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37 pp

QUESTIONS PRESENTED FOR REVIEW

1. Whether the Eleventh Amendment to the Constitution of the United States bars respondents' suit to obtain prospective relief to prevent a state official from violating the Supremacy Clause of the United States Constitution by enforcing a state law that is preempted by a federal statute.

2. Whether the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001, *et seq.*, preempts a state statute that prohibits employee welfare benefit plans from providing benefits through selective networks of medical providers.

PARTIES TO THE PROCEEDING

Pursuant to Rule 29.6 of the Rules of this Court, respondents state the following: Respondent CIGNA Healthplan of Louisiana, Inc. (now renamed CIGNA HealthCare of Louisiana, Inc.) is a wholly-owned subsidiary of CIGNA Health Corp., which is a wholly-owned subsidiary of Connecticut General Corporation, which is a wholly-owned subsidiary of CIGNA Holdings, Inc., which is a wholly-owned subsidiary of CIGNA Corporation, a publicly held corporation. CIGNA Healthplan of Louisiana, Inc. has no subsidiaries.

Respondent Connecticut General Life Insurance Company is a wholly-owned subsidiary of Connecticut General Corporation, which is a wholly-owned subsidiary of CIGNA Holdings, Inc., which is a wholly-owned subsidiary of CIGNA Corporation, a publicly held corporation. Connecticut General Life Insurance Company has no subsidiaries in which outside persons might have an interest.

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This Court should deny the petition for *certiorari* to the extent that it presents the question whether the Eleventh Amendment to the Constitution of the United States bars this action. The district court rejected petitioner's assertion of an Eleventh Amendment defense as "patently without merit." (Pet. 23a n.2.) The Court of Appeals agreed with that assessment, finding it "well established that the federal courts have jurisdiction to hear suits against state officials

where, as here, the plaintiffs seek only prospective declaratory or injunctive relief to prevent a continuing violation of federal law." (Pet. 3a n.1.) The Court of Appeals also correctly decided that this Court's decision in *Seminole Tribe of Florida v. Florida*, 116 S. Ct. 1114 (1996), did not alter this conclusion. (Pet. 4a n.1.) Because the decision below is squarely supported by this Court's precedent, no reason exists for this Court to review the Eleventh Amendment question.

Although they prevailed below, respondents nonetheless urge this Court to grant the petition for *certiorari* limited to the question of whether Louisiana's "any willing provider" statute is preempted by ERISA. The specific preemption question presented is one that this Court has not addressed and as to which the lower courts are divided. It is of fundamental importance not only to petitioner and officials of other states and to respondents and other entities that offer managed health care coverage, but also to sponsors and participants of ERISA plans that are increasingly subjected to state regulation of the type that ERISA's preemption provision was designed to avoid.

Respondents administer for ERISA-regulated employee benefit plans, many of which operate in multiple states, a network of selectively contracted medical providers, such as physicians. The Louisiana statute at issue directly prohibits respondents and their employee benefit plan customers from using a selective provider network in that state. It provides, both by its express terms and its necessary effect, that an ERISA-covered employee benefit plan or other "group purchaser" may not, regardless of the plan's

provisions, provide health care benefits through a provider network unless that network is open to any and all providers willing to contract on the network's terms and conditions. *See* La. Rev. Stat. Ann. § 40:2202(5)(c) (1992). Although the Court of Appeals correctly held this statute preempted as applied to ERISA-covered employee benefit plans, the pervasive and recurring nature of this question, its nationwide impact, and the conflict in legal analysis among the lower courts warrant the grant of *certiorari*.

ERISA's preemption provision represents a congressional judgment that employee benefit plans should be free to develop their own uniform benefit and administrative structures instead of being subject to a "patchwork scheme of regulation." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987). In *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Co.*, 115 S. Ct. 1671 (1995) ("*Travelers*"), this Court held that a state statute that did not directly regulate ERISA-covered employee benefit plans but merely had the "indirect economic influence" of raising the costs borne by such plans was not preempted by ERISA. The Court left undisturbed, however, its longstanding precedent that ERISA preempts state laws directly affecting the structure and administration of employee benefit plans. Although the court below correctly recognized that *Travelers* had not altered the preemption analysis as to such laws, other courts have reached inconsistent conclusions and results. Review by this Court is necessary to resolve whether a state any willing provider statute that prohibits employee benefit plans from offering benefits through limited provider networks is preempted by ERISA.

Despite the intense public debate over issues of health care costs and delivery, Congress has not modified ERISA's preemptive effect or generally amended ERISA to restrict plan sponsors' freedom in health plan design but has continued "to allow the free marketplace to work out such competitive, cost effective, medical expense reducing structures as may evolve." *Davidowitz v. Delta Dental Plan of Cal., Inc.*, 946 F.2d 1476, 1481 (9th Cir. 1991). Increasingly, however, state regulation has sought impermissibly to encroach on the operation of employee benefit plans by, among other things, prohibiting or restricting managed care features that are integral to the plans' design. The fact that Louisiana's "any willing provider" statute is one of many such statutes underscores the nationwide scope of the clash between ERISA's protection of the freedom of employee benefit plans to structure their own benefit programs and many states' efforts to restrict that freedom.

Not surprisingly, this conflict between regulatory schemes has already led to substantial litigation that has produced judicial decisions with divergent analyses and results. As the petition notes, the Court of Appeals for the Fourth Circuit has issued a decision reaching a result inconsistent with the decision below and upholding a Virginia any willing provider statute against a challenge based on ERISA preemption. *See Stuart Circle Hosp. Corp. v. Aetna Health Mgmt.*, 995 F.2d 500 (4th Cir.), *cert. denied*, 510 U.S. 1003 (1993). Moreover, some courts have read this Court's decision in *Travelers* as altering the preemption analysis and reopening the question of whether ERISA preempts state laws that directly affect the structure and administration of employee benefit plans. The court

below held that *Travelers* did not affect preemption of the Louisiana statute. The Supreme Court of Connecticut has, however, employed a very different analysis of *Travelers* in concluding that ERISA does not preempt claims that one of respondents' affiliates had violated a state law regulating PPO contracting practices. *See Napoletano v. CIGNA HealthCare of Conn., Inc.*, 680 A.2d 127 (Conn. 1996).

Resolution of the question presented is urgently needed because of its broad and nationwide impact on health care benefits received by the majority of American workers and their families. An estimated 114 million Americans receive health care benefits through employee welfare benefit plans subject to ERISA.[1] In response to the spiraling cost of health care, employers and unions that sponsor such ERISA plans have frequently incorporated "managed care" features into their plan design.[2] In contrast to a traditional fee-for-service or indemnity plan that reimburses all or a portion of the fee charged by a medical service provider, "managed care" seeks to integrate the benefit and delivery aspects of health care so as to provide quality health care at

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[1] *See* U.S. General Accounting Office, Health, Education, and Human Services Div., *Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA* (GAO/HEHS-95-167) (1995) ("1995 GAO Report") at 2, 45. *See also* Employee Benefit Research Institute Education and Research Fund, *EBRI Databook on Employee Benefits* (3d ed. 1995) at Table 8.8.

[2] *See* U.S. General Accounting Office, Human Resources Div., *Managed Health Care: Effect on Employers' Costs Difficult to Measure* (GAO/HRD-94-3) (1993) ("1993 GAO Report") at 3-4 (discussing the growth of managed care since 1980).

an affordable cost.[3] Among the most frequently used managed care programs are network-based programs, such as preferred provider organizations ("PPOs") and health maintenance organizations ("HMOs") of the type offered by respondents here.[4] So prevalent have these types of programs become that recent statistics show that they are available to upwards of 90 million persons who are participants or beneficiaries in ERISA welfare plans.[5]

Absent review by this Court, litigation over ERISA preemption and any willing provider laws will only increase, and the conflicts among the lower courts will likely only deepen.[6] Without this Court's resolution of the issue,

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[3] *See Arizona v. Maricopa County Med. Soc.*, 457 U.S. 332, 339 n.7 (1982) (discussing the difference between traditional health insurance plans and managed care programs); 1993 GAO Report at 23-31 (discussing key elements of managed care).

[4] *See* 1993 GAO Report at 6-12; *see also* Douglas A. Hastings, *et al.*, eds., *Fundamentals of Health Law* 258-260 (1995).

[5] *See* 1993 GAO Report at 5-7; *see also* 1995 GAO Report at 20 n.39 (reflecting that in 1994, nearly two-thirds of individuals with employer-based insurance were enrolled in network-based managed care).

[6] Legal commentators have also noted the unanswered nature of the question presented here. *See, e.g.*, Jesselyn Alicia Brown, *ERISA and State Health Care Reform: Roadblock or Scapegoat?*, 13 Yale L. & Pol'y Rev. 339, 380-81 (1995) (discussing uncertainties regarding preemption of any willing provider laws by ERISA); Gary A. Francesconi, *ERISA Preemption of "Any Willing Provider" Laws -- An Essential Step Toward National Health Care Reform*, 73 Wash. U. L.Q. 227 (1995) (same).

employee benefit plans will be free to adopt limited provider networks in some states but not in others, and ERISA's goal of promoting uniform national regulation of such plans will remain elusive. This case presents this important issue in a summary judgment context and on a record of undisputed material facts. Accordingly, respondents urge the Court to grant *certiorari* limited to the question of ERISA preemption.

I. This Court Should Deny Certiorari on the Eleventh Amendment Question

There is no conflict in authority requiring resolution by this Court as to the Eleventh Amendment question presented by petitioner. To the contrary, it is well settled that the Eleventh Amendment does not bar actions to enjoin state officials like petitioner from enforcing state laws that are preempted by federal law. As the district court and the Court of Appeals both held, such actions for prospective relief against state officials have long been allowed under the doctrine established in *Ex parte Young*, 209 U.S. 123 (1908). Just last term, this Court in *Seminole Tribe of Florida v. Florida*, 116 S. Ct. 1114, 1131 n.16 (1996), affirmed the vitality of this doctrine in cases like this one, stating that "an individual may obtain injunctive relief under *Ex parte Young* in order to remedy a state officer's ongoing violation of federal law."

In *Ex parte Young*, the Court held that the Eleventh Amendment does not bar suits against state officers to enjoin them from violating federal law, reasoning that a state officer who (as here) seeks to enforce an unconstitutional

statute is stripped of his official or representative character. 209 U.S. at 159-60; *see also Scheuer v. Rhodes*, 416 U.S. 232, 237 (1974). Following *Ex parte Young*, federal courts have routinely entertained suits against state officials seeking prospectively to prevent those officials from enforcing state laws that violate the Supremacy Clause of the Constitution. Most notably, the Court unanimously applied this rule to ERISA preemption suits in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983). There, the Court held that the *Ex parte Young* doctrine empowered plaintiffs to sue to enjoin state regulation that was preempted by ERISA, stating that "[i]t is beyond dispute that federal courts have jurisdiction over suits to enjoin state officials from interfering with federal rights." *Id.* at 96 n.14.[7]

Contrary to petitioner's argument that this case is "dissimilar[ ]" from cases involving "traditional *Ex parte Young* analysis," Pet. 25, this is precisely the type of action encompassed by the *Ex parte Young* doctrine. Respondents sued the Attorney General of Louisiana, who is responsible for enforcing the any willing provider law,[8] and who was

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[7] As *Shaw* makes clear, petitioner is plainly wrong in his contention that *Ex parte Young* applies only if the state official seeks to enforce "a criminal statute with intimidating provisions and penalties." (*See* Pet. 27.)

[8] Petitioner argues this suit is barred by the Eleventh Amendment because it was purportedly brought against Louisiana itself. (Pet. 7.) However, as both the trial court and the Court of Appeals noted, the body of respondents' complaint makes clear that the only defendant in the suit is the Attorney General of Louisiana, rendering this argument meritless. (Pet. 23a n.2 (citing

acting to enforce that law against respondents. Because the Louisiana statute is preempted by ERISA, the Attorney General's efforts to enforce it violated the Supremacy Clause. Respondents' action to enjoin the Attorney General from acting in violation of the Supremacy Clause falls precisely within the realm of actions permitted under *Ex parte Young*. As this Court stated in *Green v. Mansour*, 474 U.S. 64, 68 (1985), "the availability of prospective relief of the sort awarded in *Ex parte Young* gives life to the Supremacy Clause." Thus, contrary to petitioner's protestations, there was nothing "novel" in the Court of Appeals' application of *Ex parte Young* to this case, and there is no reason to review or reverse its decision.

Petitioner's reliance on *Seminole Tribe* is equally misplaced, since *Seminole Tribe* does not affect *Ex parte Young*'s application here. In *Seminole Tribe*, the Court held that Congress lacked the authority under the Indian Commerce Clause to abrogate Florida's Eleventh Amendment immunity to suit, 116 S. Ct. at 1131-32, an issue irrelevant to this case. In so holding, the Court stressed that it was not disturbing the traditional *Ex parte Young* cause of action, stating that "an individual can bring suit against a state officer in order to ensure that the officer's conduct is in compliance with federal law." *Id.* at 1131 n.14; *see also id.* at 1131 n.16.

While *Seminole Tribe* also held that Congress could not have intended to permit suits against state officials for

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Jones v. Louisiana ex rel. Bd. of Trustees, 764 F.2d 1183, 1185-86 (5th Cir. 1985)); Pet. 3 n.1.).

prospective relief where it had "prescribed a detailed remedial scheme for the enforcement against a State of a statutorily created right," *id.* at 1132, those circumstances are not present here. As the Court of Appeals noted, respondents do not seek to invoke any remedial scheme involving enforcement against a State. (Pet. 4a n.1.) Rather, respondents seek to prevent petitioner from violating the Supremacy Clause by encroaching on legal terrain that Congress has deemed exclusively the province of federal law.

In short, the decision of the Court of Appeals that the Eleventh Amendment does not bar this action is fully consistent with this Court's decisions, and there is no conflict in authority among the circuit courts requiring resolution by this Court. Accordingly, to the extent it seeks review of this question, the petition should be denied.[9]

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[9] In *Coeur D'Alene Tribe of Idaho v. Idaho*, 42 F.3d 1244 (9th Cir. 1994), *cert. granted*, 63 U.S.L.W. 3672 (U.S. Apr. 15, 1996) (No. 94-1474), a tribe sued to establish its purported right, under an Executive Order ratified by Congress, to land to which Idaho also claimed title. The Ninth Circuit held that the tribe could sue Idaho officials under *Ex parte Young* for relief establishing its rights to those lands. *Id.* at 1251-52. Even if this Court reversed that ruling, it would not alter the analysis in this case. Unlike *Coeur D'Alene*, this case involves efforts to enjoin a state official from violating the Supremacy Clause. Indeed, Idaho recognized in its brief that *Ex parte Young* applies to cases like this one, arguing that there (unlike here) "[t]he injunctive relief that the Tribe seeks is not tailored to enforcement of allegedly unconstitutional state statutes by state officers." Br. of Pet., No. 94-1474 at § (I)(c)(1) (filed May 30, 1996).

II. This Court Should Grant Certiorari on the ERISA Preemption Question

1. Section 514(a) of ERISA provides, with certain exceptions, that the provisions of ERISA

> shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.

29 U.S.C. § 1114(a). One of the relevant exceptions is contained in ERISA § 514(b)(2)(A) which provides generally that the broad preemptive effect of § 514(a) shall not apply to "any law of any State which regulates insurance." This Court has construed both of these provisions many times, *see, e.g., Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983) ("relate to" clause) and *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985) (insurance "savings" clause), and most recently in its interpretation of the "relate to" clause in *Travelers*.

The question presented here, which has not previously been addressed by this Court, is whether, in light of *Travelers*, a state statute may, as Louisiana's any willing provider statute does, directly regulate the structure and administration of ERISA-covered employee benefit plans.[10]

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[10] Respondents recognize that this Court has pending before it another case involving ERISA's preemption provision. *See California Div. of Labor Standards Enforcement v. Dillingham Constr. N.A., Inc.* (No. 95-789), *cert. granted*, 64 U.S.L.W. 3689 (U.S. Apr. 15, 1996). The preemption issue in that case, however, arises in a far different context and may well be resolved on grounds that would not affect the analysis or result in this case.

The Court of Appeals faithfully followed this Court's decisions in holding that Louisiana's any willing provider statute was preempted because it "relate[s] to" ERISA-governed employee benefit plans and is not saved from preemption as a law "which regulates insurance." (Pet. 10a-11a, 15a.) Review by this Court is nonetheless warranted because of the national importance of the preemption question presented and the conflict and disarray among the lower courts over that issue.

2. Managed care programs such as those offered by respondents and affected by the Louisiana statute arose in response to marketplace demands from employee benefit plan sponsors for alternatives to indemnity programs that could control health care costs while assuring quality and access.[11] Generally speaking, managed care is a process by which the parties responsible for paying for health care services intervene in the health care delivery process in various ways in order to reduce the costs of such care and improve the quality of such care.[12]

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[11] *See* 1993 GAO Report at 2-6. HMOs and other managed care organizations have also been vigorously encouraged by both federal and state legislation. *See, e.g.*, Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e, *et seq.*; Health Maintenance Organization Act, N.Y. Pub. Health Law § 4400, *et seq.* (1995). *See also* 1993 GAO Report at 7 n.7 (discussing impact of legislation on the rapid growth of managed care); Douglas A. Hastings, *et al.*, eds., *Fundamentals of Health Law* 252 (1995).

[12] *Id.* at 245.

One popular method utilized by many insurers and other managed care organizations, including respondents, is to offer care through "preferred provider" panels or networks, referred to as PPOs.[13] PPOs selectively contract with physicians, hospitals, and others to obtain services for PPO participants at a discounted rate from normal charges. The preferred providers also agree to comply with various quality and utilization management requirements. In turn, the PPO will limit the size of its provider panel and will include incentives to its participants to encourage them to obtain care through the preferred provider panel. The expectation is that most participants will choose to utilize the provider network, resulting in a greater volume of patients for these providers. Increased patient volume, in turn, provides an incentive to the preferred providers to discount their fees. Similar networks are used to operate HMOs, in

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[13] Respondents offer a variety of health care coverages and administrative services to employee benefit plans. Respondent CIGNA Healthplan of Louisiana, Inc. is a licensed HMO that provides prepaid health care coverages to its subscribers through a network of selectively contracted medical providers, such as physicians. This provider network is offered to health care consumers both directly and through employee benefit plans, insurers, and other groups. (Pet. 6a.) Respondent Connecticut General Life Insurance Company is a licensed insurer that makes this network available to employee benefit plans, both on a fully insured basis and for use by self-funded or non-insured plans to which it provides administrative services. (*Id.*)

which the network is frequently the exclusive vehicle for obtaining prepaid care.[14]

Limiting the size of the provider network is key to its success. Providers are willing to discount their charges in light of the prospect of a high volume of referrals from the network and prompt payment from a single source. By limiting the number of providers, the network administrator is able to establish and monitor quality controls and to avoid the excess costs of dealing with an unlimited number of providers.[15] These quality and cost advantages directly

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[14] *Hastings, et al., Fundamentals of Health Law* at 245, 248; 1993 GAO Report at 6-10.

[15] *See* 1993 GAO Report at 9-10; Anthony J. Dennis, *Potential Anticompetitive Effects of Most Favored Nation Contract Clauses in Managed Care and Health Insurance Contracts*, 4 Ann. Health L. 71, 72 (1995) (discussing economics of provider panels); Bruce D. Platt, *Dispelling the Negative Myths of Managed Care*, 23 Fla. St. U.L. Rev. 489, 499 (1995) ("'Any Willing Provider' legislation defeats the entire concept of managed care"); Karen A. Jordan, *Managed Competition and Limited Choice of Providers: Countering Negative Perceptions Through a Responsibility to Select Quality Network Physicians*, 27 Ariz. St. L.J. 875, 915 (1995); Atkinson & Co., *Cost Impact of "Any Willing Provider" Legislation* (1994) (cost for a typical independent practice association would rise by forty-three percent under an any willing provider mandate); Wyatt Co., *Cost Analysis of State Legislative Mandates on Six Managed Health Care Practices* 3 (1991). The Federal Trade Commission has also recognized the detrimental effects of any willing provider laws on competition and has issued opinion letters urging states to discontinue laws that prohibit insurers from maintaining cost effective preferred provider arrangements. *See* Gary A. Francesconi, *ERISA Preemption of "Any*

benefit employee benefit plans that contract with the network to provide benefits to employees and their families. Depending on a plan's design, networks can provide either an exclusive or optional form of benefit delivery for an employee benefit plan, and network benefits can be provided through an insurance policy or an administrative-services-only basis to self-funded or non-insured plans.

As of 1992, the GAO found that over half of all private employers provided network-based managed care to their employees, covering 90 million persons.[16] Despite the growth and spread of network-based health care, the ability of respondents and their competitors to make high quality and low cost provider panels available to employee benefit plans is threatened by the proliferation of "any willing provider" statutes similar to the statute at issue in this action. Although the judgment in this case prevents enforcement of the Louisiana statute against respondents as applied to employee benefit plans, 25 other states have some type of any willing provider law on their books.[17] Therefore, al-

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Willing Provider" Laws -- An Essential Step Toward National Health Care Reform, 73 Wash. U. L.Q. 227, 262 n.159, 265 (1995) (collecting citations to FTC letters).

[16] *See* 1993 GAO Report at 5-7.

[17] *See* Ala. Code § 27-45-3 (Supp. 1994); Ark. Code Ann. § 23-79-114(b) (Michie Supp. 1993); Conn. Gen. Stat. Ann. § 38a-471 (West 1982); Del. Code Ann. tit. 18, § 7301 (Supp. 1994); Fla. Stat. Ann. § 408.706 (West Supp. 1995); Ga. Code Ann. §§ 33-20-16 (1976); Idaho Code § 41-3937 (Supp. 1995); 215 Ill. Comp. Stat. Ann. 5/370h (West 1993); Ind. Code Ann.

though respondents can now maintain limited provider networks in Louisiana, they or their affiliates in other states must still contend with similar laws in these states. States continue to enact any willing provider laws,[18] and both states and private parties continue to bring suit to enforce laws already on the books.[19] Indeed, prior to instituting

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§ 27-8-11-3(b)-(c) (Michie 1994); Ky. Rev. Stat. Ann. § 304.17A-110 (Banks-Baldwin Supp. 1994); 1994 Mass. Acts 60, §§ 148-49, 241; 1994 Minn. Laws 2927; Miss. Code Ann. § 41-83-3 (1994); N.H. Rev. Stat. Ann. § 420-B:12(V) (Supp. 1994); 1994 N.J. Laws SB 886/AB 1221; N.C. Gen. Stat. § 58-51-37 (1994); N.D. Cent. Code § 38.2-4209(B)-(D) (1994); Ohio Rev. Code Ann. § 1742.09(B)(2) (Anderson 1996); Okla. Stat. Ann. tit. 36, § 3634 (West Supp. 1994-95); S.D. Codified Laws § 58-18-37 (Michie 1990); Tex. Ins. Code Ann. art. 20A-14(g)(h) (West 1996); Utah Code Ann. § 31A-22-617 (1991); Va. Code Ann. § 38.2-3407 (Michie Supp. 1996); Wis. Stat. Ann. § 628.36 (West 1995); Wyo. Stat. Ann. § 26-22-503(a)(1) (Michie Supp. 1995). These do not include variations such as "price differential laws," which govern the difference in the allowable reimbursement for use of out-of-network services, and "due process laws," which mandate that health plans follow certain procedures in selecting and deselecting providers. *See Any Willing Provider Laws: Regulating the Health Care Provider's Contractual Relationship with the Insurance Company*, The Health Lawyer: The ABA Forum on Health Law 7 (1994-95).

[18] *See* Group Health Ass'n of America, *State Managed Care Legislative Resource* (1996).

[19] *See, e.g., American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc. and Prudential Ins. Co. of Am.*, No. 96-10084-MEL (D. Mass. filed Jan. 17, 1996) (suit by pharmacies alleging violation of Massachusetts any willing pharmacy law).

this action, respondents were sued by a physician under the Louisiana law and were threatened with actions by the petitioner Attorney General as well as by other private parties. (Pet. 7a.)[20]

3. Litigation over whether ERISA preempts any willing provider laws has produced divergent and conflicting results. At least one decision has, like the decision of the Court of Appeals in this case, held that ERISA preempts the state statute. *See Blue Cross and Blue Shield of Ala. v. Nielsen*, 917 F. Supp. 1532 (N.D. Ala. 1996). Others have held that the state statute was not preempted because it was saved as a law "which regulates insurance" even though it "relate[s] to" employee benefit plans. *See Stuart Circle Hosp. Corp. v. Aetna Health Mgmt.*, 995 F.2d 500 (4th Cir.), *cert. denied*, 510 U.S. 1003 (1993); *Texas Pharmacy Ass'n v. Prudential Ins. Co. of Am.*, 907 F. Supp. 1019 (W.D. Tex. 1995). A recent decision from the Connecticut Supreme Court holds that causes of action to enforce a Connecticut statute that prohibits a provider network from excluding

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[20] Moreover, any willing provider statutes are merely illustrative of the proliferation of statutes regulating managed care practices that has occurred in the mid-1990s. States have recently enacted a multitude of provisions regulating the delivery of health care benefits which -- similar to any willing provider laws -- have the effect of mandating the structure of benefits provided by employee benefit plans. For example, "direct access" laws require closed-panel health plans to permit participants to bypass network gatekeeper requirements and access the services of certain specialists. "Freedom of choice" laws require closed-panel health plans to offer or reimburse out-of-network services.

willing providers based on criteria that have not been publicly filed are not preempted because they do not "relate to" employee benefit plans. *See Napoletano v. CIGNA HealthCare of Conn., Inc.*, 680 A.2d 127 (Conn. 1996). Absent review and further guidance from this Court, employee benefit plans will be subject not to the uniform nationwide regulation mandated by ERISA, but to the patchwork of state regulation that ERISA's preemption provision was designed to prevent.

4. The Court of Appeals correctly determined that the Louisiana statute "relate[s] to" ERISA-covered employee benefit plans on two separate bases. Nonetheless, there is disagreement and conflict in the lower courts about the meaning and application of the "relate to" test after this Court's decision in *Travelers*.

a. The Court of Appeals correctly held that the Louisiana statute "relate[s] to" employee benefit plans because it directly refers to them and includes them within its regulatory ambit. As the Court of Appeals noted, the Louisiana statute specifically prohibits exclusion from the PPO of any "licensed provider...who agrees to the terms and conditions of the preferred provider contract." (Pet. 10a.) PPOs are defined in the statute as "contractual...agreements between a provider or providers and a group purchaser or purchasers to provide for alternative rates of payment." La. Rev. Stat. Ann. § 40:2202(5)(a). A "group purchaser," in turn, is defined in language that directly encompasses employee benefit plans, as including:

> [e]ntities which contract for the benefit of their...employees, or members such as...Taft-

> Hartley trusts, or employers who establish or participate in self funded trusts or programs.

La. Rev. Stat. Ann. § 40:2202(3)(a). Employers or employee associations which contract to provide health care "for the benefit of their...employees or members" thereby establish "employee welfare benefit plans" subject to ERISA. *See* ERISA § 3(1), 29 U.S.C. § 1002(1); *see also Donovan v. Dillingham*, 688 F.2d 1367, 1371-73 (11th Cir. 1982). The Louisiana statute's application to ERISA plans is made even more explicit by its reference to "Taft-Hartley trusts"[21] as well as to "employers who establish...self funded trusts or programs." La. Rev. Stat. Ann. § 40:2202(3)(a). Given its express application to ERISA-covered employee benefit plans, the Louisiana statute "relate[s] to" such plans for preemption purposes "on that basis alone." *See District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 130 (1992).

b. The Court of Appeals also correctly held that the Louisiana statute "relate[s] to" ERISA plans because it prohibits an employee benefit plan from being structured to deliver benefits through a limited provider network. In reaching this conclusion, the Court of Appeals carefully considered the impact of this Court's decision in *Travelers*. In *Travelers*, this Court reviewed a New York statute that imposed surcharges on hospital bills payable through commercial insurance but not on bills payable by Blue Cross

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[21] *See NLRB v. Amax Coal Co., Div. of Amax, Inc.*, 453 U.S. 322, 334 (1981) (noting the applicability of ERISA to trust funds established to comply with the Taft-Hartley Act).

or Blue Shield. 115 S. Ct. at 1674-75. The Court held that the statute did not "relate to" employee benefit plans because it had only the "indirect economic effect" on the plans of raising the cost of commercial insurance and giving them an incentive to obtain coverage through Blue Cross. *Id.* at 1679. The Court noted that the New York statute merely "influenced a plan's shopping decision" but did not "mandat[e] employee benefit structures" or "bind plan administrators to any particular choice." *Id.* Recognizing, in contrast, that the Louisiana statute "specifically mandates that certain benefits available to ERISA plans must be constructed in a particular manner," the Court of Appeals correctly decided that the "limited *Travelers* holding...leaves undisturbed our conclusion that Louisiana's Any Willing Provider statute is preempted by ERISA." (Pet. 13a.)

5. A far different reading of *Travelers* has, however, been adopted by other courts. Nowhere is this conflict more evident than in a recent decision of the Connecticut Supreme Court that relied on *Travelers* to resolve the preemption issue adversely to respondents' Connecticut affiliate. *See Napoletano v. CIGNA HealthCare of Connecticut, Inc.*, 680 A.2d 127 (Conn. 1996). *Napoletano* (and a companion case addressed in the same opinion, *Hollis v. CIGNA HealthCare of Connecticut, Inc.*) involved a Connecticut statute, 1994 Conn. Pub. Acts 235, titled "An Act Concerning Managed Care." The Connecticut statute requires a preferred provider network to file with a state commission and make available to a provider "the general criteria for its selection or termination of health care providers" to the extent that such criteria are not proprietary or of a competitive nature. If the criteria have not been publicly filed, a network "may not

reject or terminate" a provider from participating in the network based on those criteria "until the provider has been informed of the criteria that his practice fails to meet." 680 A.2d at 131 n.3, quoting 1994 Conn. Pub. Acts 235(e)(2).

Plaintiffs in *Napoletano* sued one of respondents' Connecticut affiliates, a network administrator, alleging various statutory and common law causes of action, including an action for violation of the Connecticut managed care statute. *Id.* at 132. Reversing a trial court decision that these causes of action were preempted by ERISA, the Connecticut Supreme Court held that the claims were not preempted because they sought to "enforce," not modify, the terms of an employee benefit plan. *Id.* at 136.

In reaching this conclusion, the Connecticut Supreme Court extensively discussed this Court's opinion in *Travelers* which it characterized as having "indicated a retreat from preemption." *Id.* at 140 n.22. Citing to *Travelers*, the court reasoned that any "costs and burdens upon the benefit plans" were insufficient to trigger preemption because "the Supreme Court has concluded that indirect costs and benefits do not result in preemption." *Id.* at 143 n.26. Similarly, citing post-*Travelers* authority from federal courts of appeal, the court reasoned that "although a successful claim...under the Connecticut statute would in effect require that CIGNA continue to employ the plaintiff physicians, such a result would not have an impermissible or burdensome effect on the administration of the plan." *Id.* at 144.

The conflict in analysis between *Napoletano* and the Court of Appeals' decision in this case goes beyond their disagreement over whether *Travelers* was intended by this

Court to "indicate[ ] a retreat from preemption." The Court of Appeals in this case held that the State of Louisiana simply could not permissibly regulate employee benefit plans and their administration. The Connecticut Supreme Court, in contrast, concluded that *Travelers* has sufficiently changed the preemption landscape that it is permissible for a state to regulate a plan's administration as long as that regulation is not, in a court's view, "burdensome." *Id.* The two analyses cannot be reconciled. Rather, they squarely conflict over whether, after *Travelers*, state regulation may directly regulate plan structure and administration.

7. The conflict in the preemption analysis among the lower courts is not limited to the "relate to" prong of ERISA § 514(a) but extends also to whether, or under what test, an any willing provider law may be "saved" from preemption under ERISA § 514(b)(2)(A) as a law "which regulates insurance." While the Court of Appeals in this case held that the Louisiana statute was not saved on this basis, the Court of Appeals for the Fourth Circuit reached the opposite result in *Stuart Circle Hospital Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir.), *cert. denied*, 510 U.S. 1003 (1993), as to Virginia's any willing provider statute. Similarly, a district court in the Fifth Circuit has followed the Fourth Circuit's decision to hold that a Texas statute applicable to pharmacies was saved as a law "which regulates insurance." *Texas Pharmacy Ass'n v. Prudential Ins. Co. of Am.*, 907 F. Supp. 1019 (W.D. Tex. 1995).

These decisions conflict in the way they analyze ERISA's insurance saving clause. This Court has held that a determination of whether a state law "regulates insurance"

for purposes of ERISA preemption should be made by considering a "common-sense" definition of insurance regulation plus an analysis of the three factors used to determine what constitutes "the business of insurance" under the McCarran-Ferguson Act. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48-49 (1987). The court below -- following its own precedent that a law is not saved from ERISA preemption unless it satisfies both the common-sense definition of insurance regulation and each of the three McCarran-Ferguson factors -- found it unnecessary to analyze anything other than the third factor since the Louisiana statute "obviously is not limited to entities within the insurance industry." (Pet. 14a & n.51, *quoting Tingle v. Pacific Mutual Ins. Co.*, 996 F.2d 105, 108 (5th Cir. 1993).) The Court of Appeals for the Fourth Circuit in *Stuart Circle*, however -- following its precedent that none of these factors is determinative -- reached the opposite result. Because decisions in the circuits are in conflict over how to analyze ERISA's insurance savings clause,[22] review by this Court is appropriate to resolve this conflict also.

8. Review by this Court is especially urgent because of the widespread use of managed care by ERISA-covered employee benefit plans throughout the country. Unless the

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[22] *Compare DeBruyne v. Equitable Life Assur. Soc. of the U.S.*, 920 F.2d 457, 468-70 (7th Cir. 1990) (requiring each factor to be met) *with Insurance Bd. Under Soc. Ins. Plan of Bethlehem Steel Corp v. Muir*, 819 F.2d 408, 411 & n.5 (3d Cir. 1987); *United Food & Comm. Workers & Employers Az. Health & Welfare Trust v. Pacyga*, 801 F.2d 1157, 1161 (9th Cir. 1986) (holding that no one factor is dispositive).

preemption question presented here is resolved by this Court, employee benefit plans will be faced with the prospect of either litigating over this preemption issue in multiple jurisdictions or simply foregoing implementation of managed care features such as limited provider networks, especially on a uniform nationwide basis. This case presents a clearcut example of a state statute that interferes with the design and administration of employee benefit plans and an undisputed factual record on which the preemption issue can be resolved. Accordingly, respondents urge the Court to grant the petition as to this issue and resolve this issue without waiting for the conflict in the lower courts to continue to fester.

CONCLUSION

For the foregoing reasons, this Court should grant the petition limited to the first question presented involving ERISA preemption.

Respectfully submitted,

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